MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP ( ) IE ( ) IC	**Response Timely Filed?** ( ) Yes (X) No
Requestor's Name and Address Jupiter Healthwork 13567 Jupiter Road Suite 106 Dallas, Texas 75238	MDR Tracking No.: M5-05-1972-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Insurance Company of the State of PA Box 19	Date of Injury: Employer's Name: Insurance Carrier's No.: 039CBAKG8771

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Did Requestor Prevail?
From	**To**		
02-04-04	**10-01-04**	**97110, 97112, 97113, 97116, 99090 and 99214 (denied for medical necessity)**	☐ **Yes** ☒ **No**
02-06-04	**06-08-04**	**97110 (see specific dates of service below)**	☐ **Yes** ☒ **No**
04-02-04	**07-27-04**	**97110 (see specific dates of service below)**	☐ **Yes** ☒ **No**
03-11-04	**07-27-04**	**97113 (see specific dates of service below)**	☐ **Yes** ☒ **No**
04-02-04	**07-27-04**	**97116 (see specific dates of service below)**	☐ **Yes** ☒ **No**
04-02-04	**04-02-04**	**97112**	☐ **Yes** ☒ **No**
06-10-04	**06-10-04**	**97112**	☐ **Yes** ☒ **No**
07-13-04	**07-13-04**	**99090**	☐ **Yes** ☒ **No**
07-27-04	**07-27-04**	**99090**	☐ **Yes** ☒ **No**
02-06-04	**02-06-04**	**97116**	☒ **Yes** ☐ **No**
03-10-04	**03-10-04**	**97116**	☒ **Yes** ☐ **No**
02-06-04	**06-10-04**	**97112 (see specific dates of service below)**	☒ **Yes** ☐ **No**
02-10-04	**06-10-04**	**97113 (see specific dates of service below)**	☒ **Yes** ☐ **No**
02-10-04	**06-08-04**	**99090 (see specific dates of service below)**	☐ **Yes** ☒ **No**
02-13-04	**02-13-04**	**99214**	☒ **Yes** ☐ **No**
02-24-04	**02-24-04**	**99080-73**	☒ **Yes** ☐ **No**
05-24-04	**05-24-04**	**99080-73**	☒ **Yes** ☐ **No**
08-24-04	**08-24-04**	**99080-73**	☒ **Yes** ☐ **No**

PART III: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code and Commission Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), the Medical Review Division assigned an Independent Review Organization (IRO) to conduct a review of the medical necessity issues between the requestor and respondent.

The Division has reviewed the enclosed IRO decision and determined that the requestor **did not prevail** on the disputed medical necessity issues.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. The therapeutic exercises, neuromuscular re-education, aquatic therapy, gait training, analysis of clinic data stored in computers and office visit rendered on 02-04-04 through 10-01-04 **were not found** to be medically necessary. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 07-12-05, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

CPT code 97110 dates of service 02-06-04, 03-02-04, 03-10-04, 03-12-04, 03-31-04, 04-13-04, 04-14-04, 04-30-04, 05-06-04 and 06-08-04 denied with denial code "R" (extent of injury). A Contested Case Hearing on 07-16-04 resolved the compensable issue, however, recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation. Reimbursement not recommended.

Review of CPT code 97110 dates of service 04-02-04, 06-10-04, 07-13-04 and 07-27-04, code 97113 dates of service 03-11-04, 07-13-04 and 07-27-04, code 97116 on dates of service 04-02-04, 04-13-04 and 07-27-04, code 97112 dates of service 04-02-04 and 06-10-04 and code 99090 on dates of service 07-13-04 and 07-27-04 revealed that neither party submitted copies of EOBs. Per Rule 133.307(e)(2)(B) the requestor did not provide convincing evidence of carrier receipt of the providers request for EOBs. No reimbursement is recommended.

CPT code 97116 dates of service 02-06-04 and 03-10-04 denied with denial code code "R" (extent of injury). A Contested Case Hearing on 07-16-04 resolved the compensable issue. Reimbursement is recommended in the amount of **$63.42 ($25.37 X 125% = $31.71 X 2 DOS).**

CPT code 97112 dates of service 02-06-04, 03-02-04, 03-10-04, 03-12-04, 03-31-04, 04-13-04, 04-14-04, 04-30-04, 05-06-04, 06-08-04 denied with denial code code "R" (extent of injury). A Contested Case Hearing on 07-16-04 resolved the compensable issue. Reimbursement is recommended in the amount of **$370.50 ($29.64 X 125% = $37.05 X 10 DOS).**

CPT code 97113 dates of service 02-10-04, 02-11-04, 02-12-04, 02-17-04, 02-18-04, 02-20-04, 02-27-04, 03-03-04 and 06-10-04 (76 units total) denied with denial code code "R" (extent of injury). A Contested Case Hearing on 07-16-04 resolved the compensable issue. Reimbursement is recommended in the amount of **$3,229.24 ($33.99 X 125% = $42.49 X 76 units.)**

CPT code 99090 dates of service 02-10-04, 02-17-04, 02-23-04, 03-02-04, 03-10-04, 03-31-04, 04-13-04 and 06-08-04 denied with denial code code "R" (extent of injury). A Contested Case Hearing on 07-16-04 resolved the compensable issue.
Code 99090 is a DOP code. Per Rule 133.307(g)(3)(D), the Requestor is required to discuss, demonstrate and justify that the payment being sought is a fair and reasonable rate of reimbursement. The Requestor has not provided sample EOBs as evidence that the fees billed are for similar treatment of injured individuals and that this is the fee charged and paid by other carriers. No reimbursement is recommended.

CPT code 99214 date of service 02-13-04 denied with denial code code "R" (extent of injury). A Contested Case Hearing on 07-16-04 resolved the compensable issue. Reimbursement is recommended in the amount of **$106.36 ($85.09 X 125%).**

CPT code 99080-73 dates of service 02-24-04 and 05-24-04 denied with denial code "R" (extent of injury). A Contested Case Hearing on 07-16-04 resolved the compensable issue. Reimbursement is recommended in the amount of **$30.00.**

CPT code 99080-73 date of service 08-24-04 denied with denial code "V" (unnecessary medical treatment with peer review). Per Rule 129.5 the TWCC-73 is a required report and not subject to an IRO review. The Medical Review Division has jurisdiction in this matter. Reimbursement is recommended in the amount of **$15.00.** A Compliance and Practices referral will be made as the carrier is in violation of Rule 129.5.

PART IV: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to a refund of the paid IRO fee. The Division hereby **ORDERS** the insurance carrier to remit the amount of $3,814.52, plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Findings and Decision by:

		08-26-05
Authorized Signature		Date of Findings and Decision
Ordered by:		
		08-26-05
Authorized Signature		Date of Order

PART V: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____

PART VI: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

7600 Chevy Chase, Suite 400
Austin, Texas 78752
Phone: (512) 371-8100
Fax: (800) 580-3123

NOTICE OF INDEPENDENT REVIEW DECISION

Date: June 13, 2005

To The Attention Of: TWCC
7551 Metro Center Drive, Suite 100, MS-48
Austin, TX 78744-16091

RE: Injured Worker:
MDR Tracking #: M5-05-1972-01
IRO Certificate #: 5242

Forté has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to Forté for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

Forté has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a chiropractic reviewer who has an ADL certification. The reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Submitted by Requester:

- Table of services
- HCFA 1500s
- Medical Reports
- Exercise logs
- TWCC forms
- Treating doctor’s response to peer review
- MRI report
- TWCC hearing decision

Submitted by Respondent:

- Letter from carriers attorney
- Table of services

Clinical History

According to the supplied documentation, the claimant sustained an injury to his lumbar spine when he was involved in a motor vehicle accident while working on ___. The claimant went to the ER and was prescribed medications. The claimant then went to his chiropractor who became his treating doctor. The claimant began passive therapy. The claimant was later transitioned to active therapy. A TWCC decision on 7/16/04 reported that the L5/S1 protrusion was a compensable injury. The claimant underwent an extensive amount of active therapy. A previous low back complaint had resulted in a lumbar disc protrusion at L5/S1 and was reported on a MRI report dated 5/16/02. The documentation ends here.

Requested Service(s)

Therapeutic exercises 97110, neuromuscular re-education 97112, aquatic therapy 97113, gait training 97116, analysis of clinical data stored in computers 99090, and office visits 99214 for dates of service 2/4/04 through 10/1/04.

Decision

I agree with the carrier that the services rendered were not medically necessary.

Rationale/Basis for Decision

The documentation supplied reveals that the claimant had a L5/S1 disc protrusion that was exacerbated by the compensable injury dated ___. The claimant underwent therapy at his treating doctor's facilities that appear reasonable and medically necessary through January 2004. At the time that the disputed services begins, there was not objective documentation supplied that would support the extensive and large amount of therapy rendered. The treating doctor did not adequately support his rationale for treatment of a lumbar disc sprain/strain with an exacerbation to his L5/S1 disc protrusion. The documentation did not reveal any thecal sac or nerve root involvement. According to the Official Disability Guidelines, pages 902 and 1138, "*Chiropractic Guidelines: Patient selection based on previous chiropractic success – Trial of 6 visits over 2-3 weeks with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks, avoid chronicity and gradually fade the patient into active self-directed care*" The therapy prior to the dates of service in question appear to have been an adequate trial of chiropractic therapy. Continued and ongoing care is not seen as reasonable or medically necessary.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to TWCC via facsimile or U.S. Postal Service from the office of the IRO on this 13th day of June 2005.

Signature of IRO Employee:

Printed Name of IRO Employee: Denise Schroeder